STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	**1001 SW 29TH ST TOPEKA, KS 66611**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS 00069507.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This Requirement is not met as evidenced by: The facility census totaled 82 residents with 17 residents in the sample. Based on observation, interview, and record review, the facility failed to focus on the resident as an individual when talking and addressing the residents during daily interactions, for 1 of 2 residents sampled for dignity. (#25) Findings included: - Review of resident #25's annual MDS (Minimum Data Set) dated 12/3/12 revealed a BIMS (brief interview for mental status) with a score of 11 (moderate impairment). The resident's mood score was 00 indicating no depression. The resident exhibited no behavioral symptoms, he/she needed extensive assistance of 1 person for bed mobility, transferring, dressing, and toilet use, needed limited assistance of one person for walking in room and personal hygiene, and was independent with no set up help for eating, and had total dependence of one staff for locomotion on and off unit. It identified the resident was on a toileting program, was occasionally incontinent of urine and was always continent of bowel.	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

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F 241	Continued From page 1 Review of the resident's quarterly MDS dated 9/30/13 revealed a BIMS with a score of 12 (moderate impairment). The resident's mood was 0 indicating no depression. He/she had no behaviors and did not reject cares. The resident needed extensive assistance of one person for bed mobility, locomotion on the unit, dressing, toilet use and personal hygiene, needed limited assistance of one person for walking in the room, needed supervision of one person for walking in the corridor, needed extensive assistance of 2 or more persons for transferring, and needed supervision with set up help only for eating. The resident was frequently incontinent of urine but was always continent of bowel, and was on a current toileting program. Review of the Communication Care Area Assessment (CAA) dated 12/7/12 revealed the following analysis of findings: The resident had a diagnosis of Alzheimers(Alzheimer's disease-progressive mental deterioration characterized by confusion and memory failure) and received Exelon and Namenda(medications used to treat dementia and Alzheimers). The resident wore bilateral hearing aids and could hear under normal conditions wearing those. Staff assisted the resident at night with taking out the hearing aides and undoing the battery. The resident had a notebook in his/her room for all staff to sign when they went to his/her room and what they did so he/she could remember events and cares. Review of the care plan dated of 10/15/13 revealed the resident preferred his/her close friend to dust his/her knick knacks, the glass door on his/her cabinets, and preferred female staff to do his/her showering/bathing. The resident wanted staff to sign in when they go in his/her	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

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F 241	Continued From page 2	F 241		

room and sign what they were doing so he/she can be reminded of who is providing care, what kind of care, and when. The care plan indicated the resident wanted visitors to knock, announce themselves, and the purpose of the visit.

Review of a "Concern Form" dated 10/22/13 revealed the resident reported he/she did not want a certain aide to work with him/her any more. The resident reported he/she asked the aide to go to the bathroom and the aide told him/her, he/she just went to the bathroom. The resident reported the aide did not take his/her time and was in and out of the room quickly. The resident had concerns about the aides attitude. The Summary/Findings included:to remove the aide from the resident's care. The Recommendations/Actions Taken included: spoke with staff regarding approach, talk about how he/she wanted to be perceived versus how he/she was being perceived by this resident. Follow up with the resident regarding the employee concern revealed he/she was pleased.

Observation on 11/6/13 at 10:02 A.M. revealed direct care staff T pushed the resident in his/her wheelchair down the hall from the beauty shop and did not interact with the resident.

On 11/6/13 at 10:46 A.M. observation revealed the resident put on his/her call light, direct care staff W came to answer the call light, knocked, on the door but did not announce him/herself was, asked the resident "did ya need something". The resident replied he/she needed to use the bathroom, staff shut the door to the room and assisted the resident.

On 11/6/13 at 5:13 p.m. observation revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

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F 241	Continued From page 3	F 241		

direct care staff P placed the resident's plate down on the table in front of him/her but did not say anything to the resident, then walked away.

On 11/6/13 at 1:20 P.M. an interview with the resident revealed there were just certain staff that he/she did not want to care for him/her. He/she did not want to discuss the subject further because when he/she told someone (unsure who he/she told) about other staff being rude to him/her before, it got back to that staff member and that staff confronted the resident saying "I heard you didn't want to work with me anymore". The resident reported this made him/her uneasy about mentioning any other problems with staff again. The resident also stated he/she considered staff being "rude" when they wouldn't help him/her to the bathroom or help him/her get up. The resident also stated he/she did not really tell the administration about the problem for fear of it getting back to the staff members on the floor.

On 11/6/13 at 1:00 P.M. an interview with direct care staff T revealed the resident preferred some staff over others. Staff T reported there were some staff the resident does not like to work with and stated the resident will ask for someone else and the facility will provide someone else right at that moment. Staff T stated he/she didn't know why the resident didn't like certain staff.

On 11/7/13 at 7:39 A.M. an interview with licensed nursing staff J revealed there were only certain staff that the resident liked to work with. He/she stated if there was a staff member that the resident didn't like, the resident would tell the nursing staff, the nursing staff would ask the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

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F 241	Continued From page 4 resident why he/she didn't like that staff or find out why he/she was asking for someone different. Staff J stated they would then either educate the aide or assign someone new to the resident. Staff J reported the expectation of staff when wheeling residents down the hall, was for staff to talk to the residents, and staff should talk to the residents in the dining room; ask them if their meal was ok,or if they needed more to drink, etc. On 11/7/13 at 7:50 A.M. an interview with social services staff II, social services staff JJ, and social services staff KK, revealed sometimes the resident had trouble transitioning from one aide to another and stated the resident had some cognitive deficits that could affect his/her preferences for aides. Staff KK reported at that time, the resident had a concern last month regarding an aide telling the resident to do something instead of asking the resident to do something. On 11/7/13 at 8:05 A.M. an interview with administrative nursing staff D revealed the expectation was for aides to be professional and conversations with the resident in mind, at all times. Staff D wanted the aides to develop relationships with the residents. Staff D also reported the expectation in the dining room was for staff to acknowledge the residents, and make sure that conversation was about residents. Staff D also reported when wheeling a resident down the hall, he/she expected the staff to make the resident feel comfortable and have professional and appropriate conversation with the resident. Review of the facility's Provision of Dignity For Each Elder Policy with an effective date of 10/6/11. revealed the following: Policy: the facility promoted care for each elder in a manner	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

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F 241	Continued From page 5 and in an environment that maintained or enhanced each elder's dignity and respect in full recognition of his/her individuality. The facility created and maintained a supportive environment for all elders, which preserved dignity and facilitated a positive self-image. The facility failed to enhance resident #25's dignity by failing to focus on the resident as an individual when talking and addressing the resident during daily interactions.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility reported a census of 82 residents. The sample included 18 residents. Based on record review, observation and interview, the	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

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F 279	Continued From page 6 facility failed to provide an individualized care plan for one resident #59. Findings Included: - The Physician's Order Sheet dated 9/1/13 for resident #59 revealed a diagnoses of sepsis (an illness in which the body had a severe response to bacteria or other germs),fractured hip, Alzheimer (progressive mental deterioration characterized by confusion and memory failure), history of alcohol abuse and muscle weakness. The 14 day Minimum Data Set (MDS) 3.0 dated 9/2/13 revealed a staff assessment for mental status noted the resident had impaired long and short term memory problems. The resident could hear with minimal difficulty with hearing aids, usually could understand others and made him/herself understood by others. The resident had adequate vision with corrective lenses. The resident exhibited inattentive behavior and disorganized thinking, physical and exhibited verbal behavior towards others, rejection of care and wandering were exhibited 1 of 3 days. The resident received pain medication and an antianxiety medication 7 of 7 days, The admission MDS 3.0 dated 8/26/13 revealed the resident had impaired long and short term memory problems. The resident could hear with minimal difficulty with hearing aids, usually could understand others and made self understood by others. The resident had adequate vision with corrective lenses. The resident exhibited inattentive behavior and disorganized thinking. The resident received pain medication and an antianxiety medication 7 of 7 days. The Care Area Assessment (CAA) dated 8/26/13.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

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F 279	Continued From page 7	F 279		

The resident lacked understanding of his/her physical and cognitive limitation and exhibited poor judgement. Staff would to continue to monitor for behavioral changes. The resident received scheduled pain medication 7 of 7 days and did not receive any non pharmacological interventions. Pain did not trigger.

The care plan dated 10/20/13 revealed the staff were to monitor for pain every shift and document the effectiveness of pain relieving medications and interventions. The care plan lacked documentation for individualized interventions for this resident.

The 9/1/13 Physicians Order Sheet revealed an order for staff to assess the resident's pain every 12 hours.

Observation on 11/5/13 at 3:33 P.M. the resident stood in the commons area and stated he/she had pain. The resident stated he/she felt he/she was going to die today. The resident was not able to describe what hurt.

Observation on 11/7/13 at 10:15 A.M. the resident sat in the commons area with staff. The resident denied pain.

Interview on 11/6/13 at 4:49 P.M. direct care staff RR stated the residents changed in behavior when he/she was in pain and licensed staff were alerted to these changes. The staff asked the resident every 2 to 3 hours if they were in pain, the resident usually grimaced when in he/she was in pain.

Interview on 11/7/13 at 10:15 A.M. direct care staff LL stated if the resident did not act right or expressed feelings of pain,staff reported to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

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F 279	Continued From page 8 nurse. If the resident reports pain the first intervention was to attempt a change of position. Interview on 11/7/13 at 11:30 A.M. licensed staff G stated the resident was started on a narcotic for pain management/she said when the resident was in pain he/she became very restless and vocalized when he/she was in pain. When the resident experienced a change in behavior, the underlying cause was usually pain. The Elder Direct Care Plan policy dated 10-10-12 provided by the facility revealed the facility would provide an individualized plan, interdisciplinary plan of care, treatment and services. The facility failed to provide an individualized plan of care for this resident to include non-pharmacological pain interventions.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This Requirement is not met as evidenced by: The facility census totaled 82 residents with 17 included in the sample. Based on observation, interview, and record review, the facility failed to provide an initial care plan sufficient to meet the needs of the resident prior to the completion of the first comprehensive care plan for 1 of 17 residents. (#109) Findings included: - Review of resident #109's signed physician orders dated 9/11/13 revealed the following	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 9	F 281		

diagnoses: chronic kidney disease stage III (a condition of deteriorating renal function) and urinary tract infection (uti). The resident was most recently admitted on 10/29/13.

Review of the admission MDS (minimum data set) dated 8/21/13 revealed a BIMS (brief interview for mental status) score of 13, indicating no cognitive impairment. The resident had clear speech and was understood by others. The resident did not have any behaviors, including rejection of care. The resident required extensive assistance of one staff for transfers, limited assistance of one staff for walking in the room and corridor, locomotion on and off the unit, toileting, and personal hygiene. The resident had an indwelling foley catheter an external catheter. A trial toileting program was not attempted. The received diuretic medications 6 of 7 days during the look back period.

Review of the Urinary Incontinence and Indwelling Catheter CAA (care area assessment) dated 8/26/13 revealed the resident had a diagnosis of BPH (benign prostatic hypertrophy-non-cancerous enlargement of the prostate which could lead to interference with urine flow, urinary frequency, and urinary tract infections) and had a foley catheter in place for quite a while per the resident. The foley was not to be removed. The resident saw a urologist routinely to have the catheter changed. Staff emptied the resident's foley every shift and recorded output and performed foley catheter care every shift per the facility policy. "Will care plan to provide catheter care and monitor for changes in urine and output that could indicate sepsis [potentially fatal whole-body inflammation from infection] or UTI".

Review of the ADL (activities of daily living)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 10	F 281		

Functional/Rehabilitation Potential CAA dated 8/26/13 revealed the facility admitted the resident for a 30 day respite stay. The resident required assistance of one staff to get up from sitting positions, stand-by assistance with a walker, and used a wheelchair for longer distances due to general weakness. The resident needed assistance with transfers and toileting, had a foley catheter that staff emptied and recorded each shift, and at times needed assistance with hygiene. The resident could self propel with a wheelchair. The resident was alert and oriented to person, place, and time. The resident had a BIMS score of 13 out of 15 and was cognitively intact.

Review of the Eagle Ridge neighborhood care plan book revealed a care plan from a previous admission was still in place. The resident's care plan for impaired mobility, dated 10/1/13, revealed on 10/3/13 the resident's foley was discontinued by a urologist. Interventions directed staff to use a straight catheter if the resident was unable to void PRN (as needed), assist with toileting as the resident demonstrated incontinence and wore pullups, assist with proper hygiene, monitor for signs and symptoms of UTI, and notify the physician of urine changes.

The resident had a temporary care plan dated 10/29/13 that revealed the resident had a foley catheter. It did not include interventions directing staff how to care for the resident's catheter.

Review of an admission note dated 10/29/13 revealed the resident admitted with a foley catheter to dependent drainage with clear yellow urine.

Review of a physician order dated 10/29/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 11 revealed an order to keep the foley catheter for urinary retention. Review of an interdisciplinary note dated 11/5/13 revealed the nurse called and spoke with the physician who stated the foley catheter needed to stay in for urinary retention and prostate problems. Observation on 11/6/13 at 11:20 A.M. revealed the resident with the foley catheter leg bag secured to the resident's leg. Interview with the resident's family member on 11/6/13 at 11:26 A.M. revealed the resident originally had a foley catheter due to prostate issues and not being able to totally empty his/her bladder. The family member reported the urologist had taken out the resident's foley and then the resident got a UTI while it was out. Interview with direct care staff P on 11/6/13 at 4:20 P.M. revealed the resident needed assistance with changing his/her catheter bag from a leg bag to a night bag each evening and then back to a leg bag in the morning. Staff P reported staff emptied and measured the resident's urine output. Interview with licensed nursing staff L on 11/7/13 at 10:44 AM. revealed if he/she had questions about the resident's care, he/she consulted the chart or the care plan. Interview with administrative nursing staff D on 11/12/13 at 3:18 P.M. revealed he/she expected the initial care plan to include interventions for staff to care for the resident. Staff D reported he/she expected the care plan to say the resident needed foley catheter care per the facility policy.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 12 Review of the facility policy for Elder Directed Care Plans, last revised 10/10/12, revealed care planning was implemented through the integration of assessment findings, consideration of the prescribed treatment plan and development of goals for the elder that were reasonable and measurable." It revealed the neighborhood nurse developed an interim, temporary care plan based on clinical assessment and information provided at the time of admission. "The Clinical Guidelines from American Health Information Management Association, Long Term Care Health Information and Documentation Guidelines, September 2001 documented Admission/Interim Care Plan - upon admission, an "initial care plan should be developed to carry through until the resident's comprehensive assessment and care plan have been developed. The care plan should address the primary reason for admission and treatment and the resident's most immediate care needs." The facility failed to develop and implement a temporary care plan sufficient to meet the needs of newly admitted resident #109.	F 281		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 13	F 314		

This Requirement is not met as evidenced by:
The facility had a census of 82 residents. The sample included 17 residents. Based on observation, interview, and record review, the facility failed to properly utilize heel pressure relief cushions resulting in the worsening of a heel pressure ulcer for 1 (#15) of 1 resident reviewed for pressure ulcers.

Findings included:

- Review of resident #15's physician's orders dated 9/11/13 revealed the following diagnoses: peripheral vascular disease (PVD-an abnormal condition affecting the blood vessels), traumatic amputation of the leg unilaterally (to one side) above the knee, post traumatic wound infection, embolism (an obstruction in a blood vessel due to a blood clot or other foreign matter that got stuck while traveling through the blood stream), and thrombosis (an abnormal condition in which a clot developed within a blood vessel) of the arteries of the lower extremities. The resident admitted to the facility on 3/5/13.

Review of the admission MDS (minimum data set) 3.0 dated 3/13/13 revealed a BIMS (brief interview for mental status) score of 10, indicating moderate cognitive impairment. The resident required extensive assistance of one staff for bed mobility and transfers. The resident did not walk, and required limited assistance of one staff for locomotion on the unit and supervision of one staff for locomotion off the unit. The resident ate independently with setup assistance. The resident did not have any oral or dental issues. The resident did not have any swallowing problems, had not had any significant weight loss, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 14	F 314		

received a therapeutic diet. The resident did not have any behaviors, including rejection of care. The resident was at risk for pressure ulcers, but did not have any healed or unhealed pressure ulcers or any venous or arterial ulcers. The resident had a pressure relieving device to the chair and bed to prevent pressure ulcers.

Review of the quarterly MDS dated 8/26/13 revealed a BIMS score of 14, indicating no cognitive impairment. The resident required extensive assistance of one staff for bed mobility and transfers. The resident did not walk, and required supervision with setup help only for locomotion on and off the unit. The resident ate independently with setup assistance. The resident did not have any swallowing problems, had no had any significant weight loss, and received a therapeutic diet. The resident did not have any behaviors. The resident was at risk for pressure ulcers, but did not have any healed or unhealed pressure ulcers or any venous or arterial ulcers. The resident had a pressure relieving device to the chair and bed to prevent pressure ulcers.

Review of the Pressure Ulcer CAA (care area assessment) dated 3/18/13 revealed the resident had no skin irritations, redness, or tender spots, had a right lower leg amputation, and dry skin behind his/her right ear. The resident's Braden Scale (a tool used for predicting the risk of developing pressure ulcers) dated 3/5/13 and 3/9/13 had a score of 19, indicating the resident did not have an increased risk of pressure ulcers. The resident's right lower leg was amputated years ago and the resident had a diagnosis of PVD, which placed him/her at risk for skin integrity issues. Other risk factors included he/she needing supervision with toileting, transfers, hygiene, and occasional incontinence from a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 15	F 314		

recent urinary tract infection. The resident had a pressure reducing mattress, cushion for his/her wheelchair, and a regular skin check in place for the prevention of pressure ulcers.

Review of the Nutrition CAA dated 3/18/13 revealed the resident met with the clinical dietary manager to discuss food preferences and completed the dietary pathway. The resident received a cardiac diet interpreted as a no added salt diet. The resident's favorite food was vanilla Greek yogurt mixed with chocolate syrup.

Review of the resident's care plan for ADL (activities of daily living) Function/Rehabilitation, last revised 11/1/13, revealed the resident had a right leg amputation and a history of PVD. Interventions directed staff to allow the resident to use a wheelchair for mobility, provide setup and stand by assistance for personal hygiene, and provide physical therapy evaluation for treatment of pain and decreased mobility.

Review of the resident's care plan for nutrition, initiated 09/03/13, revealed interventions that directed staff to provide the resident a multivitamin daily (added 10/30/13), provide a prostat (protein supplement) 30 ml (milliliters) twice a day (added 10/20/13), provide a regular diet, encourage intake of at least 75%(percent) at meals and encourage snack consumption for adequate caloric intake, document the resident's intake, offer menu alternatives if the resident refused to eat, offer and encourage at least 500 ml of fluid at each meal and in between, monitor for signs and symptoms of dehydration, notify the physician of abnormalities, provide weekly skin integrity checks, assist with moisturizer application, provide weekly weights, monitor for significant weight changes, provide an air

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 16	F 314		

mattress, provide a cushion for his/her wheelchair, encourage high protein foods at meals (added 11/4/13), may crush pills or give with pudding or ice cream, provide a Heels Up cushion (added 10/28/13), place Duoderm dressing to the left heel and change every 3 days (added 10/28/13). The resident's care plan did not identify the resident was at risk for skin conditions.

Review of a physician visit form dated 10/7/13 revealed the physician noted bruising to the left hip, a LBKA (left below the knee amputation) without prosthesis, but no other skin issues were identified.

Review of a skin assessment record dated 10/12/13 revealed the resident had a dark purple/brownish bruise to his/her left ankle and a fading purple bruise to the back of the right hip/flank area from a fall. No concerns were noted to the resident's heel.

Review of the Braden Scale completed on 10/13/13 was 17, indicating the resident was at risk for pressure ulcers.

Review of a general skin check assessment dated 10/27/13 revealed the resident had a light healing bruise to the left ankle, and a fading purplish bruise to the back of the right hip/flank area, but no issues were identified with the resident's left heel.

Review of the Braden Scale completed on 10/27/13 was 16, indicating the resident was at risk for pressure ulcers.

Review of a skin assessment record dated 10/28/13 revealed the resident had a 2 cm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 17	F 314		

(centimeter) by (x) 2 cm x 0 cm circular black area to the left heel with uneven intact surrounding skin. Staff listed treatment as a Duoderm dressing daily to be changed every 3rd day. This was the first documentation of the heel ulcer in the resident's chart.

Review of the physician order dated 10/28/13 revealed instructions for Duoderm to the left heel daily and change every 3 days and prn (as needed) if soiled.

Review of a skin note dated 10/29/13 revealed staff identified the day prior, a dark area on the inner aspect of the resident's left inner heel and apply duoderm to protect the area per the physician on rounds. This morning the Duoderm was missing from the heel and the dark area was noted to be soft and boggy to the touch. The nurse contacted the physician's office and received an order to seek wound care evaluation. Staff made an appointment for November 20, 2013 with the wound specialist. The nurse protected the area of the heel with a soft adhesive dressing and a soft shoe. Staff failed to document would measurements.

Review of a physician order dated 10/30/13 revealed an order for liquid protein 30 ml by mouth (po) daily for supplementation, cranberry supplement one tablet BID (twice daily) to reduce incidence of UTIs (urinary tract infections), and a multivitamin one tablet po TID (three times a day) for supplementation.

Review of a skin assessment record dated 11/3/13 revealed the resident had a blackened area with a mushy center to his/her left heel. No measurements were recorded. Staff listed the treatment as a Duoderm dressing daily to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 18	F 314		

changed every 3rd day. No wound measurements were documented.

Review of a nutritional status note by the dietician on 11/4/13 revealed the dietician had reviewed the resident's nutritional status related to the area on the resident's left heel being blackened with a mushy center. A liquid protein supplement, cranberry supplement, and multivitamin were ordered to address the nutritional part of the treatment. The resident did not select any protein item from the menu for the meal that day and staff offered a peanut butter and jelly sandwich, which the resident accepted. The resident's weight was stable.

Review of the October 2013 MAR revealed the resident received the multivitamin, cranberry supplement, and protein supplement as scheduled.

Review of the Certified Nurses Aide daily charting for October 2013 revealed the resident ate breakfast twice, once on 10/12/13, when he/she ate 100% and on 10/21/13, when he/she ate 25%. For lunch, the resident ate 100% on 17 days, 75% on 8 days, 25% on 2 days, and did not eat one day. Staff did not chart on 2 days. For supper the resident ate 100% on 3 days, 75% on 19 days, 50% on 2 days, and did not eat on 3 days. Staff did not chart on 4 days.

Review of the November 2013 MAR (medication administration record) revealed the resident received the multivitamin, liquid protein supplement, and cranberry supplement as scheduled with the exception of 11/2/13, when he/she refused the protein supplement.

Review of the CNA (certified nurse aide) daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 19	F 314		

charting for November 2013 revealed the resident did not eat breakfast 11/1/13 through 11/6/13. The resident ate 100% of lunch each day, and at supper ate 75% on 4 days and 100% on one day.

Observation on 11/5/13 at 5:32 P.M. revealed the resident sat in his/her wheelchair and had eaten 100% of his/her meal and ate ice cream.

Observations on 11/6/13 at 7:10 a.m., 7:22 A.M., 7:43 A.M., and 7:59 A.M. revealed the resident lay on his/her back with his/her legs flat in bed on an air mattress with his/her eyes closed. The resident did not have any cushioning under his/her leg and his/her left foot lay on the bed.

Observation on 11/6/13 revealed direct care staff R was in the resident's room assisting his/her roommate from 7:43 A.M.- 8:06 A.M. and did not check on the resident's positioning or reposition the resident during that time.

Observation on 11/6/13 at 8:17 A.M. revealed direct care staff R assisted the resident to sit up in bed, then using a gait belt, transferred the resident into the wheelchair. The resident wore a non-skid blue sock on his/her left foot that appeared to be over a bulky bandage. The resident did not have a device in the bed to elevate or float his/her heels.

Observation on 11/6/13 from 8:31 A.M. to 8:46 A.M. revealed the resident sat in his/her wheelchair in the bathroom in front of the sink with the ball of his/her left foot resting on the floor.

Observation on 11/6/13 at 8:57 A.M. revealed the resident sat in the bathroom in front of the sink and washed his/her face and hands with a washcloth with the ball of his/her left foot resting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 20 on the floor. Observation on 11/6/13 at 12:23 P.M. revealed staff served the resident grapes, mashed potatoes, peas, pork roast, and vanilla ice cream. The resident ate all the mashed potatoes, peas, and ice cream, all but a few grapes and only a few bites of the pork roast. The resident wore the same blue sock on his/her left foot as observed before over a bulky bandage. Observation on 11/6/13 at 4:34 P.M. revealed the resident lay in bed with his/her eyes closed, a cushion under his/her calf, and his/her left heel resting on the bed. The resident's feet were not covered and easily visible, as the resident lay on top of the bed covers and was partially covered with a quilt. Observation on 11/7/13 at 7:11 A.M., 7:24 A.M., 7:43 A.M., and 7:58 A.M., revealed the resident lay in bed, his/her eyes closed, legs flat with a cushion under his/her calf and his/her left heel resting on the bed. Observation on 11/7/13 at 8:17 A.M. revealed the resident lay in bed with his/her eyes open, his/her left leg bent at the knee, and the sole of his/her left foot flat on the bed. Observation 11/7/13 at 8:30 A.M. revealed licensed nursing staff J washed his/her hands, put on gloves, and took off a cushioned heel protector sock as the resident complained of pain. Staff J apologized and removed the sock and then a soiled Duoderm dressing. The wound was dark purplish red, and round with intact skin, on the inner portion of the resident's left heel. Staff J measured the resident's wound to be 2.5 cm x 2 cm with no depth. Staff then put on a	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 21	F 314		

clean Duoderm dressing and replaced the cushioned heel protector sock. The resident's left leg was pink and without edema.

Interview with direct care staff R on 11/6/13 at 8:29 A.M. revealed the resident required assistance with transfers and toileting because he/she had been getting weaker.

Interview with direct care staff R on 11/7/13 at 10:43 A.M. staff needed to position the Heels Up Cushion under the left leg so the residents heel was off the bed surface and staff should use when ever the resident was in bed. Staff R reported the resident moved his/her leg well and could reposition his/her leg on his/her own. Staff R reported usually the resident did not go to breakfast because he/she liked to sleep late, but ate an oatmeal bar in the morning if he/she did not go to breakfast. Staff R reported the resident had a good appetite. Staff R reported he/she had to encourage the resident to eat something in the morning, but for lunch the resident ate really well. Staff R reported the resident kept snacks in his/her room.

Interview with direct care staff S on 11/6/13 at 4:17 P.M. revealed the resident did not have any skin conditions.

Interview on 11/6/13 at 5:21 P.M. with licensed nursing staff I revealed he/she knew the resident had a Duoderm to the left heel as a preventive measure, but did not know of any current skin conditions. Staff reported the resident had PVD that made him/her more at risk for skin conditions.

Interview with licensed nursing staff L on 11/7/13 at 7:28 A.M. revealed the resident knew what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 22	F 314		

he/she wanted and made his/her needs known. Staff L reported he/she did not know of any skin conditions the resident had because the charge nurse completed the assessments, but he/she knew staff were doing everything to keep pressure off the resident's heel. Staff L reported interventions in place for the resident included encouraging the resident to drink and eat and repositioning him/her. Staff L reported every resident in the facility was at risk for skin conditions due to their older age, but the resident had an amputation in the past, which made him/her at a higher risk. Review of the resident's chart revealed it lacked documentation of the type of ulcer.

Interview with licensed nursing staff J on 11/7/13 at 8:44 A.M. revealed the resident had the sore on his/her left heel for about 2 weeks. Staff J reported the physician looked at it each week when he/she was in the facility and gave an order for the Duoderm dressing to the heel to be change every 3 days and when soiled. Staff J reported the resident had poor circulation and the sore on his/her left heel was a venous stasis ulcer (from poor blood circulation). Staff J reported the interventions in place for the resident were a pressure reducing air mattress on the bed that adjusted according to the resident's pressure points every 15 minutes, the charge nurse measured and assessed the wound weekly, and the resident had a heels off cushion that was used while the resident was in bed.

Interview with licensed nursing staff J on 11/7/13 at 2:06 P.M. revealed staff should position the heels off cushion under the resident's calf so the resident's foot was not on the bed.

Interview with administrative nursing staff D on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 23 11/7/13 at 2:10 P.M. revealed the the resident had a heels up pad that went on the end of the bed to raise up the resident's heels off of the bed. Staff D confirmed the cushion should lay under the resident's lower calves to keep his/her heels up off the surface of the bed. Staff D also reported the resident had an air mattress, a Duoderm dressing to the left heel, had an appointment scheduled with a wound clinic on November 20, 2013, and took a protein supplement and multivitamin. Interview on 11/12/13 at 4:18 P.M. with physician PP, revealed he/she had examined the wound to the resident's heel and it appeared to be a pressure ulcer from laying on the sheets. Staff PP reported the area had initially presented on 10/28/13 and the resident had a follow-up appointment later in the month. Staff PP reported he/she expected the facility to follow their policies and procedures for preventing the pressure sore from worsening. Review of the facility policy for Pressure Ulcer Prevention and Management, last revised 11/1/12, revealed, "Elders that develop ulcers over bony prominences of their feet will be assessed by a physician to determine the etiology of the ulcer (pressure ulcer versus diabetic foot ulcer). Elders with ulcers on lower extremities will be assessed by a physician to determine the etiology [cause] of the ulcer(s). The physician's diagnosis will be recorded in the elder's clinical record." Review of the facility policy for Skin Care, last revised 11/1/12, revealed, "If the elder is determined to be at risk or has developed any skin integrity abnormalities, the neighborhood nurse will implement action according to the	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 24 specific skin issue identified per protocol including but not limited to: Preventing injury to the elder by maintaining and improving tissue tolerance to pressure in order to prevent injury. Protecting against adverse effects of external mechanical forces. The neighborhood nurse with the assistance of the Nurse Management Team will educate staff on how to identify risk for and prevent pressure ulcers. The neighborhood nurse and the Interdisciplinary team will plan and implement preventative care to avoid complications resulting from an elder's inactivity including:... Maintaining proper body position and alignment..." The facility failed to provide interventions to prevent the development of a Stage 2 pressure ulcer and failed to provide interventions as planned after the pressure ulcer developed for this cognitively impaired resident who required staff assistance.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: The facility identified a census of 82 residents. The sample included 17 residents of which 2 were reviewed for catheters. Based on	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 25	F 315		

observation, record review, and interview, the facility failed to provide catheter care for one (#144) resident.

Findings included:

- The October 2013 Physician's Order Sheet for resident #144 documented a diagnosis of urinary retention (a lack of ability to urinate). It noted an order for a urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

The Admission Minimum Data Set 3.0 dated 10/3/13 noted a Brief Interview for Mental Status score of 15 (13 to 15 indicated intact cognition). It documented the resident had an urinary catheter.

The Care Area Assessment dated 10/3/13 for urinary incontinence and indwelling catheter noted the resident returned from the hospital with the urinary catheter.

The care plan dated 10/8/13 noted staff provided catheter care each shift, secured the catheter to the resident's thigh to prevent pulling, and kept the catheter bag below waist level.

Observation on 11/6/13 at 8:00 A.M. staff provided cleansing to the resident's buttocks, but did not clean the catheter. Staff did not secure the catheter to the resident's upper leg. Staff raised the catheter drainage bag above the resident's waist. The resident sat at the bathroom sink, and the catheter bag fell off the wheelchair onto the floor. Staff wheeled the resident out of the bathroom, rolling over the catheter tubing, and dragging the catheter bag on the floor. Staff transferred the resident to the recliner, and hung the catheter bag on the lever of the recliner. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 26 catheter bag was left touching the floor. Observation on 11/7/13 at 8:00 A.M. staff provided cleansing to the resident's buttocks, but did not clean the catheter. Staff did not secure the catheter to the resident's upper leg. Staff raised the catheter drainage bag above the resident's waist. Staff transferred the resident to the wheelchair, and hung the catheter bag under the seat. The catheter bag hung down onto the floor. Staff transferred the resident to the recliner, hung the catheter bag on the lever of the recliner, and the catheter bag touched the floor. Interview on 11/7/13 at 8:40 A.M. direct care staff CC stated he/she kept the catheter bag empty, cleaned around the area, and did catheter care at least everyday. Interview on 11/6/13 at 4:40 P.M. licensed care staff H expected direct care staff to perform appropriate catheter care, secure the catheter tubing to the resident's leg, keep the catheter bag and the tubing below waist level, free hanging, and off the floor. Interview on 11/7/13 at 3:15 P.M. administrative nursing staff expected staff to follow the facility policy with regard to catheter care. He/she expected staff to complete catheter care every shift, and to handle the catheter bag so the catheter was not pulled. He/she said staff should keep the catheter bag below the resident's waist, and not on the floor. The facility policy "Foley Catheter Care" documented staff were to "cleanse the catheter twice daily. The catheter should be taped to the upper thigh to avoid tension on the catheter. The drainage bag should be kept at a level lower than	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 27 the bladder". The facility failed to provide catheter care, failed to maintain the catheter at proper height during transfers/cares, and failed to secure the catheter for this resident with an indwelling urinary catheter.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility identified a census of 82 residents. The sample included 6 residents for review of medications. Based on observation, record	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 28	F 329		

review, and interview, the facility failed to monitor one resident (#85) for medication effectiveness.

Findings included:

- The July 2013 Physician's Order Sheet for resident #85 documented a diagnosis of depression (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). It noted orders for Miralax (a laxative) and Colace (a stool softener) as needed.

The Admission Minimum Data Set 3.0 dated 6/8/13 noted a Brief Interview for Mental Status score of 5 (less than 7 indicated severely impaired cognition). It indicated the resident received antidepressant medications for 7 of the previous 7 days.

The Admission Care Area Assessments (CAA) dated 6/8/13 for cognition noted the resident had an increase in use of pain medication, a decrease in food intake, impacting cognition and recall. It documented the resident demonstrated anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). He/she had a decline in intake which could be due to dementia (progressive mental disorder characterized by failing memory, confusion) and depression.

Bowel monitoring records for June 2013 and July 2013 revealed blank entries or lack of a bowel movement on 6/1/13 to 6/7/13, (6 days) 6/23/13 to 6/26/13 (3 days), 7/12/13 to 7/17/13 (5 days), and 7/19/13 to 7/22/13 (3 days).

Medication records for June 2013 and July 2013 lacked documentation of the administration of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 29 Colace. Interview on 11/7/13 at 1:40 P.M. direct care staff Y stated he/she reported a change in moods, skin conditions, loss of bladder or bowel, or lack of bowel movements. Interview on 11/7/13 at 8:55 A.M. licensed nursing staff F stated the nurse received a print out every shift of residents who did not have a bowel movement in the previous 3 days. The nurse then verified with the staff and the resident to confirm the lack of a bowel movement, and offered the resident an as needed medication. The facility failed to provide a policy on bowel monitoring. The facility failed to effectively monitor bowel movements and administer the as needed medications for this resident.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This Requirement is not met as evidenced by: The facility census totaled 82 residents. Thirty six medication administrations were observed for 11 residents. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent (%), with 2 medication errors affecting 2 residents (#23, #118), making the medication error rate 5.5%. Findings included:	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 30	F 332		

- Observation on 11/5/13 at 12:34 p.m. revealed that licensed nursing staff N crushed an enteric coated 81 mg (milligram) tablet of aspirin and administered it in applesauce to resident #23.

Review of the resident's September 2013 signed physician order summary revealed directions with the aspirin order to not crush the medication. The summary also lacked an order to crush the resident's medications.

During an interview with licensed nursing staff N on 11/5/13 at 12:40 P.M. he/she confirmed the resident did not have an order for staff to crush the resident's medications.

Interview on 11/7/13 at 12:42 P.M. with licensed nursing staff G revealed staff should not crush the medications that were enteric coated. Staff G reported the resident would not take his/her medications unless they were crushed and in food, but staff G did not know if staff contacted the physician for an order to crush the medications.

Interview with administrative nursing staff D on 11/7/13 at 2:10 P.M. revealed he/she did not know if enteric coated medications could be crushed. Staff D looked up the information on the computer and found that enteric coated medications should not be crushed and reported the nursing staff should not crush the medications with enteric coating. Staff D reported if an enteric coated medication needed to be crushed to be given, he/she expected the nurse to contact the physician to determine if there was a better option.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 31 Review of the facility policy for Medication Administration, last revised 10/15/11, revealed staff would administer all medications for every elder as ordered by a physician. The facility failed to ensure resident #23 was free of medication errors by crushing an enteric coated medication without a physician order. - Observation on 11/5/13 at 12:30 P.M. revealed licensed nursing staff N removed one tablet of calcium 600 milligrams (mg) plus 200 mg vitamin D and administered it to resident #118. Review of the September 2013 physician order summary revealed an order for calcium 600 mg. Interview on 11/7/13 at 12:42 P.M. with licensed nursing staff G confirmed there were not any calcium 600 mg tablets in the medication cart available for use and the resident's order was for calcium 600 mg. Staff G reported he/she would have called the physician and asked if it was okay to give the vitamin D with the calcium and if not, he/she would have called the pharmacist to order the correct medication. Interview with administrative nursing staff D on 11/7/13 at 2:10 P.M. revealed he/she expected when staff gave medications, for them to pull up the medication order and follow the order. Review of the facility policy for Medication Administration, last revised 10/15/11, revealed all medications would be administered for every elder as ordered by a physician. The facility failed to ensure resident #118 was free of medication errors by ensuring the resident's calcium was administered as ordered.	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 32	F 334		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 33 already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This Requirement is not met as evidenced by: The facility had a census of 82 residents. Five residents were sampled for immunizations. Based on record review and interview, the facility failed to provide documentation the pneumonia vaccine was offered, refused, or received in the past for 2 of 5 residents, failed to provide documentation of education given prior to administration of the pneumonia vaccine for 1 of 5 residents and failed to provide documentation of education given prior to administration of the influenza vaccine for 1 of 5 residents, involving residents' #31, #13, #10, #93.	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 34 Findings included: Review of resident #31's medical record on 11/7/13 revealed no documentation staff offered the resident the pneumonia vaccine and no documentation the resident had received or refused the vaccine in the past. Review of resident #13's medical record on 11/7/13 revealed no documentation staff offered the resident the pneumonia vaccine and no documentation the resident received or refused the vaccine in the past. Review of resident #110's medical record on 11/7/13 revealed staff did not provide education prior to administration of the pneumonia vaccine. Review of resident #93's medical record on 11/7/13 revealed staff did not provide education prior to administration of the influenza vaccine. Review of the facility immunization policy revised on 10/16/2011 revealed each elder's immunization status was determined, if possible, prior to vaccination and was documented in the elder's clinical record. All current and newly admitted elders was offered the influenza vaccine from September of each year through the end of March the following year. All admissions throughout the year was offered the pneumovax (pneumonia) injection if the resident had not had the immunization in the past or had the vaccine prior to the age of 65 years old and it was longer than 5 years since administration. Prior to offering the influenza and pneumovax immunization each elder and/or surrogate decision-maker would receive education regarding the benefits and potential side effects of the immunization. Elders may refuse	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 35 vaccinations. Vaccination refusal and the reason was documented by the facility. During an interview on 11/7/13 at 1:41 P.M. administrative nurse staff D reported if a resident received an immunization outside of the facility, documentation should be in the computer system. Staff D revealed the "Education provided" tab was marked if an immunization was given by the facility. Staff D could not find documentation for the pneumonia vaccine for resident #31 and #13 as well as no education provided for resident #110 and #93. The facility failed to provide the pneumonia vaccination for residents #31 and #13, and failed to provide education to residents' #110 and #93 for the influenza vaccine.	F 334		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility census totaled 82 residents. Based on observation and interview, the facility failed to distribute and serve food under sanitary conditions during food service from one main kitchen and 4 kitchenettes. Findings included:	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 36 - Observation on 11-4-13 at 11:48 AM revealed direct care staff V served drinks to the residents in the dining area. Staff V wore a hair net which partially covered his/her hair with unrestrained hair visible. Staff V also touched the drinking surface of the resident's cups. Observation on 11-4-13 at 11:51 AM revealed a direct care staff served water to the residents and rested the water pitcher on the drinking surface of several different residents' cups while he/she poured water into the cup. Observed direct care staff Z wore a hair net with his/her hair unrestrained on the entire back of his/her head. Observation on 11-4-13 at 11:55 A.M. revealed direct care staff U touched the drinking surface of the resident's cups with his/her hands. Observation on 11-6-13 at 11:47 A.M. revealed direct care staff AA walked around in the kitchen area with no hair or beard net in place. Observation on 11-6-13 at 12:07 P.M. revealed dietary staff touched the food surface area on the plates he/she removed from the clean plate rack prior to placing resident's food on the plates. Staff touched his/her nose to push up his/her glasses and continued to serve the resident's plates without washing his/her hands. Observation on 11-6-13 at 12:30 P.M. revealed dietary staff FF put on gloves, handled the outside of a plastic bread bag, obtained utensils from another container, took meat out of another plastic bag, touched the meat, then placed the same gloved hand on top of the sandwich, and used a utensil to cut the food into two pieces. Staff touched multiple surfaces with the same	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 37	F 371		

gloves then touched the resident's food with the contaminated gloves.

During an interview on 11-7-13 at 2:05 P.M. dietary staff EE revealed he/she expected staff to practice good hygiene, which included proper use of hair nets, washing hands, and handling dishes appropriately. Staff EE reported the facility staff had frequent in-services about good hygiene.

Review of the facility's Preparing and Serving Lunch and Supper policy, with a date of 10/25/11, revealed staff should don hair net or hair restraint prior to food preparation. The policy did not address handling food surfaces of serving dishes.

The facility failed to distribute and serve food under sanitary conditions and failed to properly wear hairnets in food preparation areas.

- Observation on 11-4-13 at 11:45 A.M. revealed direct care staff removed plastic drinking glasses from the storage rack and stacked the glasses and distributed to the resident's tables. The staff did not wear gloves and touched the drinking surfaces of the glasses.

Observation on 11-4-13 at 11:50 A.M. revealed direct care staff removed a stack of bowls from the cabinet above the sink. The staff placed their fingers in the food surface of the top bowl to remove the dishes from the cabinet.

Observation on 11-4-13 at 11:55 A.M. revealed direct care staff with gloved hands removed beverages from the refrigerator and placed them in the ice bucket for serving, without changing gloves, removed a glass and touched the drinking surface of the glass. The staff removed two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 38 plates from the cabinet and touched the food surface area. Observation on 11-4-13 at 12:05 P.M. revealed direct care staff served food with gloves, and retrieved the dietary book, opened the pages, then returned to serving food and touching the food surface area of the plates without changing gloves. Observation on 11-4-13 at 12:07 P.M. revealed direct care staff used tongs at the salad cart and picked up a piece of fruit resting on the ice and placed it back into the bowls of salad staff served to the residents. Observation on 11-4-13 at 12:15 P.M. revealed direct care staff removed a serving scoop from the bin of serving utensils by the bowl of the scoop and handed it to the serving staff. Observation on 11-4-13 at 12:20 P.M. revealed direct care staff moved a piece of chicken on a resident's plate using gloved hands that previously held plates. During interview on 11-7-13 at 2:05 P.M. dietary staff EE revealed he/she expected staff to practice good hygiene which included proper use of hair nets, washing hands and handling dishes appropriately. Staff EE reported the facility staff had frequent in-services about good hygiene. Review of the facility's Preparing and Serving Lunch and Supper policy, with a date of 10/25/11, revealed staff should don hair net or hair restraint prior to food preparation. The policy did not address handling food surfaces of serving dishes. The facility failed to distribute and serve food	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

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F 371	Continued From page 39 under sanitary conditions. - During the initial tour of the kitchen on 11/4/13 at 10:00 A.M., unsampled dietary staff wore a cap without a hair net. Hair was noted to be uncovered at the nape of the neck. Observation of the kitchen on 11/6/13 11:00 A.M. unsampled dietary staff opened a bag of bread with gloved hands that touched all surface areas in the kitchen. Staff reached inside of the bag, and removed the bread. Staff did not change gloves or use tongs to handle the bread. Interview on 11/7/13 2:05 P.M. dietary staff EE expected staff to practice good hygiene, including the use of hair nets, handwashing, and appropriate handling of dishes. The facility policy "Preparing and Serving Lunch and Supper" noted staff were to don a hair net. It lacked documentation of how to handle food. The facility failed to serve and prepare food in a sanitary manner.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 40 This Requirement is not met as evidenced by: The facility identified a census of 82 residents. The sample included 6 residents for review of medications. Based on observation, record review, and interview the facility's pharmacy consultant failed to acknowledge the lack of monitoring for one resident (#85) for medication effectiveness. Findings included: - The July 2013 Physician's Order Sheet for resident #85 documented a diagnosis of depression (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). It noted orders for Miralax (a laxative) and Colace (a stool softener) as needed. The Admission Minimum Data Set 3.0 dated 6/8/13 noted a Brief Interview for Mental Status score of 5 (less than 7 indicated severely impaired cognition). It indicated the resident received antidepressant medications for 7 of the previous 7 days. The Admission Care Area Assessments (CAA) dated 6/8/13 for cognition noted the resident had an increase in use of pain medication, a decrease in food intake, impacting cognition and recall. It documented the resident demonstrated anxiety. He/she had a decline in intake which could be due to dementia (progressive mental disorder characterized by failing memory, confusion) and depression. Bowel monitoring records for June 2013 and July 2013 revealed blank entries or lack of a bowel movement on 6/1/13 to 6/7/13, 6/23/13 to 6/26/13, 7/12/13 to 7/17/13, and 7/19/13 to	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 41 7/22/13. Medication records for June 2013 and July 2013 lacked documentation of the administration of Colace. Review of Drug Regimen Reviews dated 6/5/13 and 7/3/13 failed to recognize the lack of bowel monitoring. Interview on 11/7/13 at 1:40 P.M. direct care staff Y stated he/she reported change in moods, skin conditions, loss of bladder or bowel control, or lack of bowel movements. Interview on 11/7/13 at 8:55 A.M. licensed nursing staff F stated the nurse received a print out every shift of residents who did not have a bowel movement in the previous 3 days. The nurse then verified with direct care staff and the resident to confirm the lack of a bowel movement, and offered the resident an as needed medication. Interview on 11/7/13 at 3:45 P.M. pharmacy consultant NN stated he/she periodically checked the resident's bowel monitoring records. The facility failed to provide a policy on bowel monitoring. The pharmacy consultant NN failed to recognize and report the facility failed to effectively monitor bowel movements and administer as needed medications for this resident. The facility failed to effectively monitor bowel movements and administer the as needed	F 428		

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F 428	Continued From page 42 medications for this resident.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This Requirement is not met as evidenced by: The facility census totaled 82 residents. Based on	F 431		

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F 431	Continued From page 43	F 431		

observation, record review, and interview, the facility failed to properly label medications and secure medications in 2 of 4 medication rooms.

Findings included:

- Observation of the Meadowlark medication room on 11/4/13 at approximately 10:15 A.M. revealed an undated open vial of Flulaval (an influenza vaccine).

Review of the package insert for FluLaval influenza vaccine revealed, once entered, staff should discard a multi dose vial after 28 days.

Interview on 11/4/13 at 10:17 A.M. with licensed nursing staff E confirmed the vial of FluLaval was undated and reported they did not know when staff opened the vial.

Interview with administrative nursing staff D on 11/7/13 at 2:10 P.M. revealed he/she expected staff to date the flu vaccine vial on the day they opened it. Staff D reported if a vial was not dated, staff were expected to throw it away.

Review of the undated facility policy for Immunizations revealed once entered staff should discard a multidose vial of FluLaval after 28 days.

The facility failed to ensure the FluLaval vaccine was properly labeled when opened.

- Observation on 11/6/13 at 3:40 P.M. revealed two Bacterium double strength (DS) tablets (an antibiotic) on the nurse's desk. The door to the nurse's station was closed, but unlocked. The nurse's station was unattended. Five cognitively impaired, independently mobile residents resided

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F 431	Continued From page 44 on this unit. Interview on 11/6/13 at 3:41 P.M. licensed nursing staff N stated he/she laid it there to remind him/her to put the order into the computer. The facility's policy "Storage of Medications" noted medications "will be stored in a locked cabinet in the medication storage area". The facility failed to store all drugs in a locked compartment.	F 431		